Responsible Pain Management

A Case Study Review of Chronic Pain and Best Practices for Patient Care

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Disclosures

Indiana Attorney General's Prescription Drug Abuse Prevention Task Force Member - Education Committee

Goals and Objectives

1. Review data that helped shape Indiana's new laws and current best practices for opioid prescribing

2. Outline a process for office implementation of safe prescribing practices in chronic pain management

3. Review the case for objective measures of treatment adherence in chronic pain management

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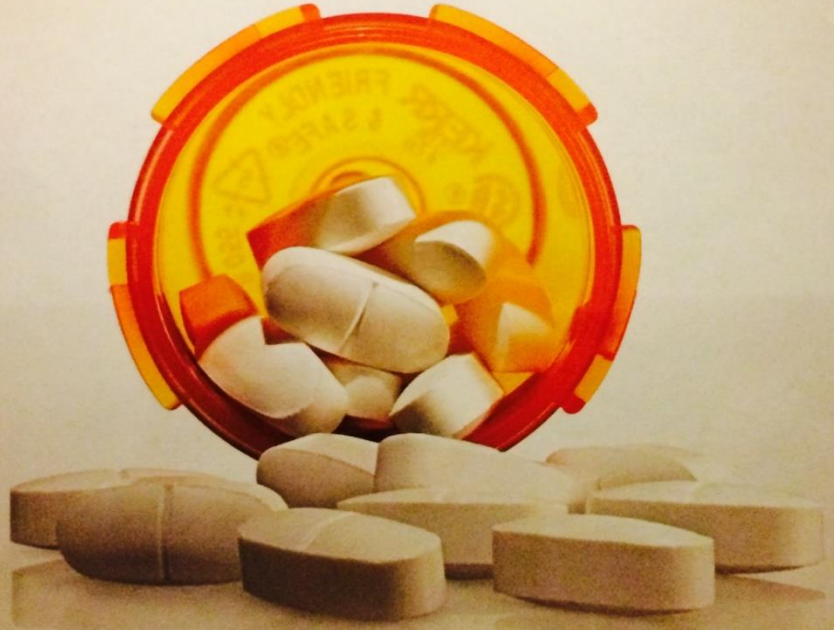
ConsumerReports®

AMERICA'S SCARY PAIN PILL HABIT

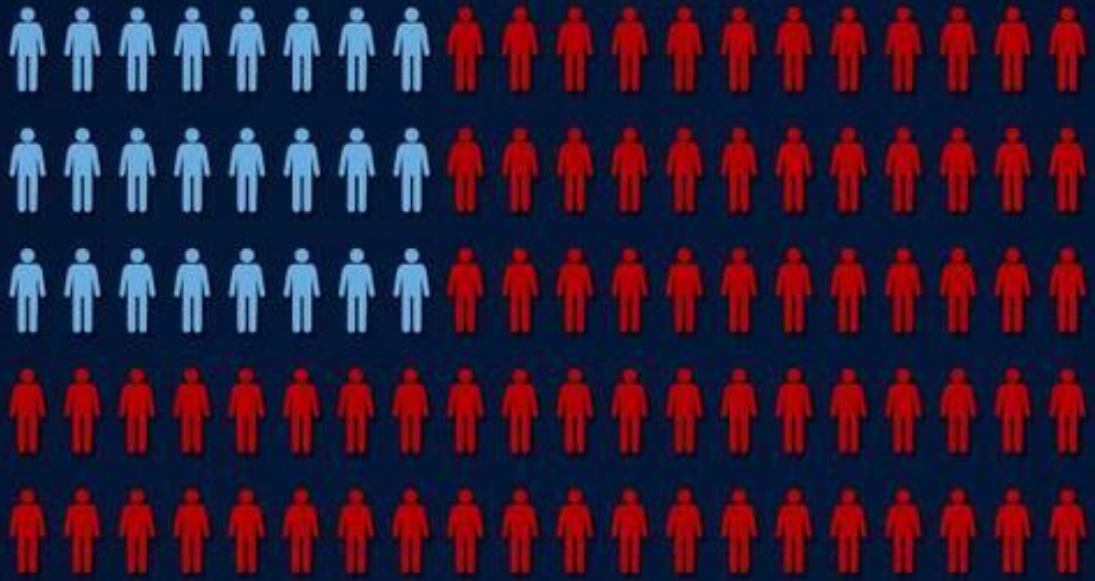
Our use of these meds is skyrocketing—and so are overdoses. Can the FDA do more to protect us?



PLUS

- Alert: Don't take too much of this popular OTC pain reliever
- The healthiest way to banish aches

100 PEOPLE DIE EVERY DAY



FROM DRUG OVERDOSES IN AMERICA.

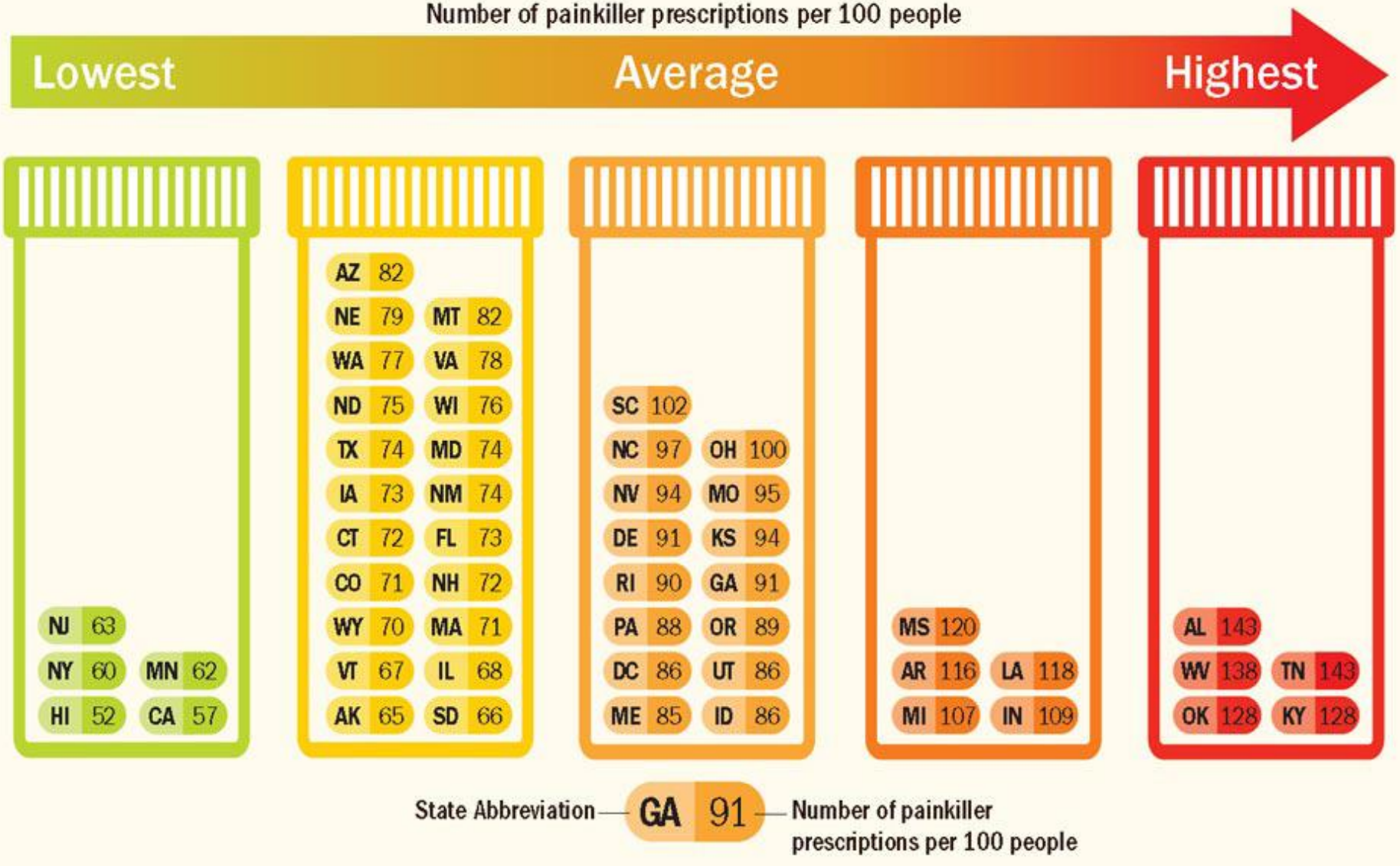
IT DOESN'T HAVE TO BE THAT WAY.

Share if you agree: first responders should carry naloxone, a life-saving overdose reversal medication.

wh.gov/drugpolicyreform **#DrugPolicyReform**

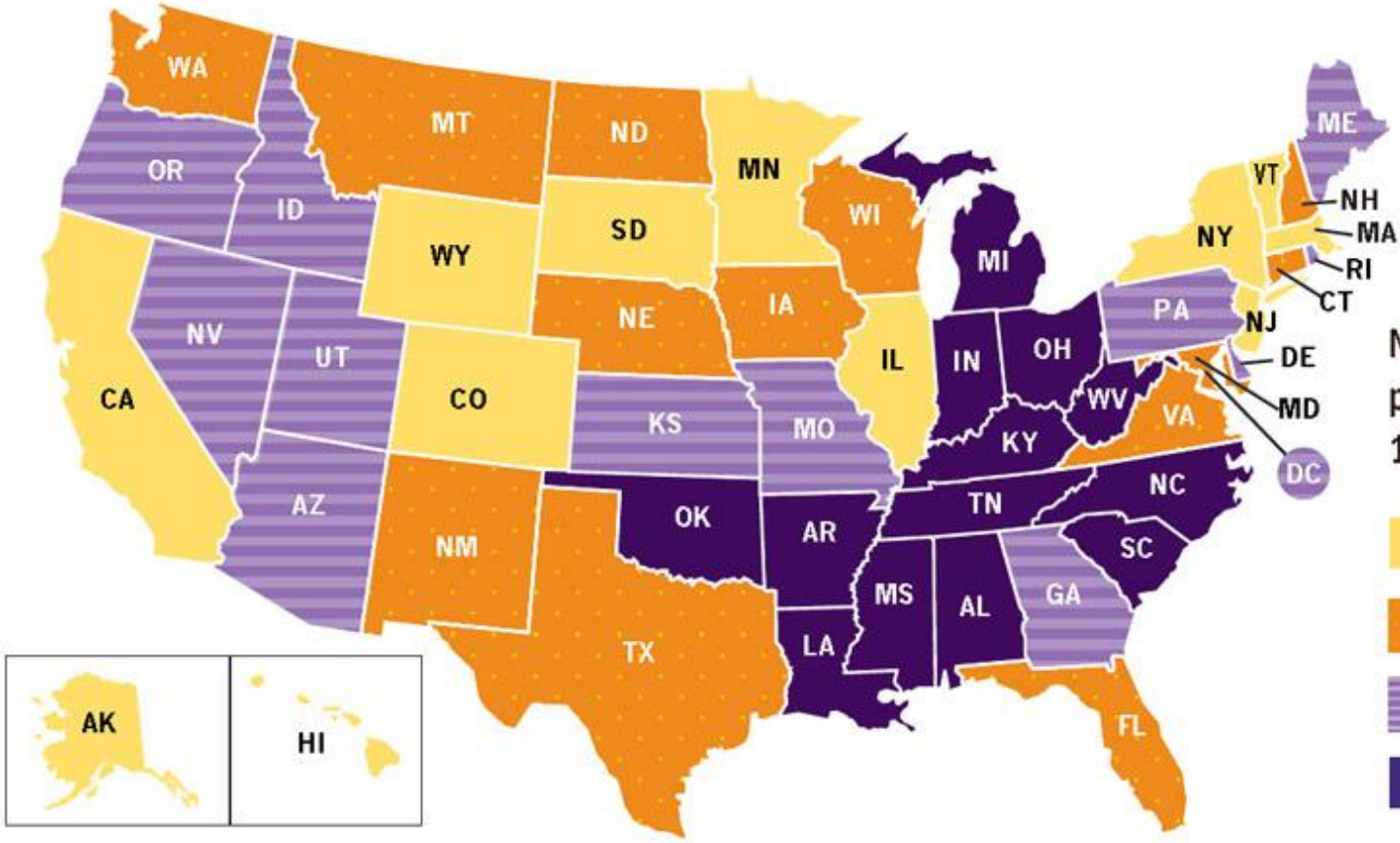
Source:
CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. MMWR 2011; 60: 1-6

Health care providers in different states prescribe at different levels.



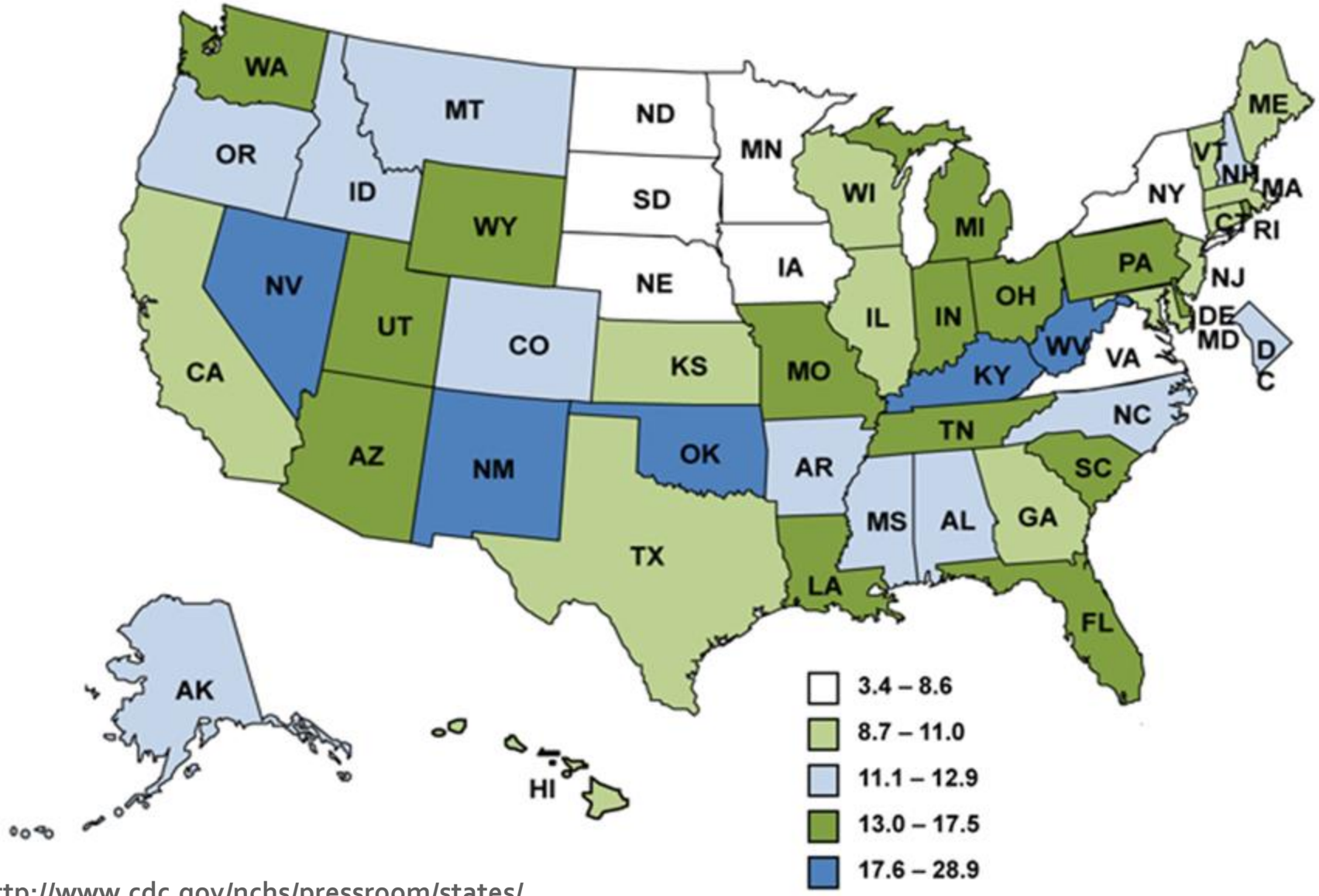
SOURCE: IMS, National Prescription Audit (NPA™), 2012.

Some states have more painkiller prescriptions per person than others.



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

Drug poisoning death rates by state: United States, 2010



http://www.cdc.gov/nchs/pressroom/states/drug_deaths_2010.pdf

*Age-adjusted deaths per 100,000 standard population

Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths

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Context The rate of prescription opioid–related overdose death increased substantially in the United States over the past decade. Patterns of opioid prescribing may be related to risk of overdose mortality.

Objective To examine the association of maximum prescribed daily opioid dose and dosing schedule ("as needed," regularly scheduled, or both) with risk of opioid overdose death among patients with cancer, chronic pain, acute pain, and substance use disorders.

Design Case-cohort study.

Setting Veterans Health Administration (VHA), 2004 through 2008.

Participants All unintentional prescription opioid overdose decedents (n=750) and a random sample of patients (n=154 684) among those individuals who used medical services in 2004 or 2005 and received opioid therapy for pain.

Main Outcome Measure Associations of opioid regimens (dose and schedule) with death by unintentional prescription opioid overdose in subgroups defined by clinical diagnoses, adjusting for age group, sex, race, ethnicity, and comorbid conditions.

Results The frequency of fatal overdose over the study period among individuals treated with opioids was estimated to be 0.04%. The risk of overdose death was directly related to the maximum prescribed daily dose of opioid medication. The adjusted hazard ratios (HRs) associated with a maximum prescribed dose of 100 mg/d or more, compared with the dose category 1 mg/d to less than 20 mg/d, were as follows: among those with substance use disorders, adjusted HR=4.54 (95% confidence interval [CI], 2.46-8.37; absolute risk difference approximation [ARDA]=0.14%); among those with chronic pain, adjusted HR=7.18 (95% CI, 4.85-10.65; ARDA=0.25%); among those with acute pain, adjusted HR=6.64 (95% CI, 3.31-13.31; ARDA=0.23%); and among those with cancer, adjusted HR=11.99 (95% CI, 4.42-32.56; ARDA=0.45%). Receiving both as-needed and regularly scheduled doses was not associated with overdose risk after adjustment.

Conclusion Among patients receiving opioid prescriptions for pain, higher opioid doses were associated with increased risk of opioid overdose death.

JAMA. 2011;305(13):1315-1321 www.jama.com

THE RATE OF OVERDOSE MORTALITY increased sharply in the United States in the past decade and overdose mortality is a pressing public health problem.[1] Between 1999 and 2007, the rate of unintentional overdose death in the United States increased by 124%,[2] largely because of increases in prescription opioid overdoses.[1,3] Achieving a better understanding of the factors contributing to prescription opioid overdose death is an essential step toward addressing this troubling and dramatic increase in overdose mortality.

There is some evidence that higher prescribed doses increase the risk of drug overdose among individuals treated with opioids for chronic noncancer pain.[4] Specifically, the risk of

LESS IS MORE

Opioid Dose and Drug-Related Mortality in Patients With Nonmalignant Pain

Tara Gomes, MHSc; Muhammad M. Mamdani, PharmD, MA, MPH; Irfan A. Dhalla, MD, MSc; J. Michael Paterson, MSc; David N. Juurlink, MD, PhD

Background: Opioids are widely prescribed for chronic nonmalignant pain, often at doses exceeding those recommended in clinical practice guidelines. However, the risk-benefit ratio of high-dose opioid therapy is not well characterized. The objective of this study was to characterize the relationship between opioid dose and opioid-related mortality.

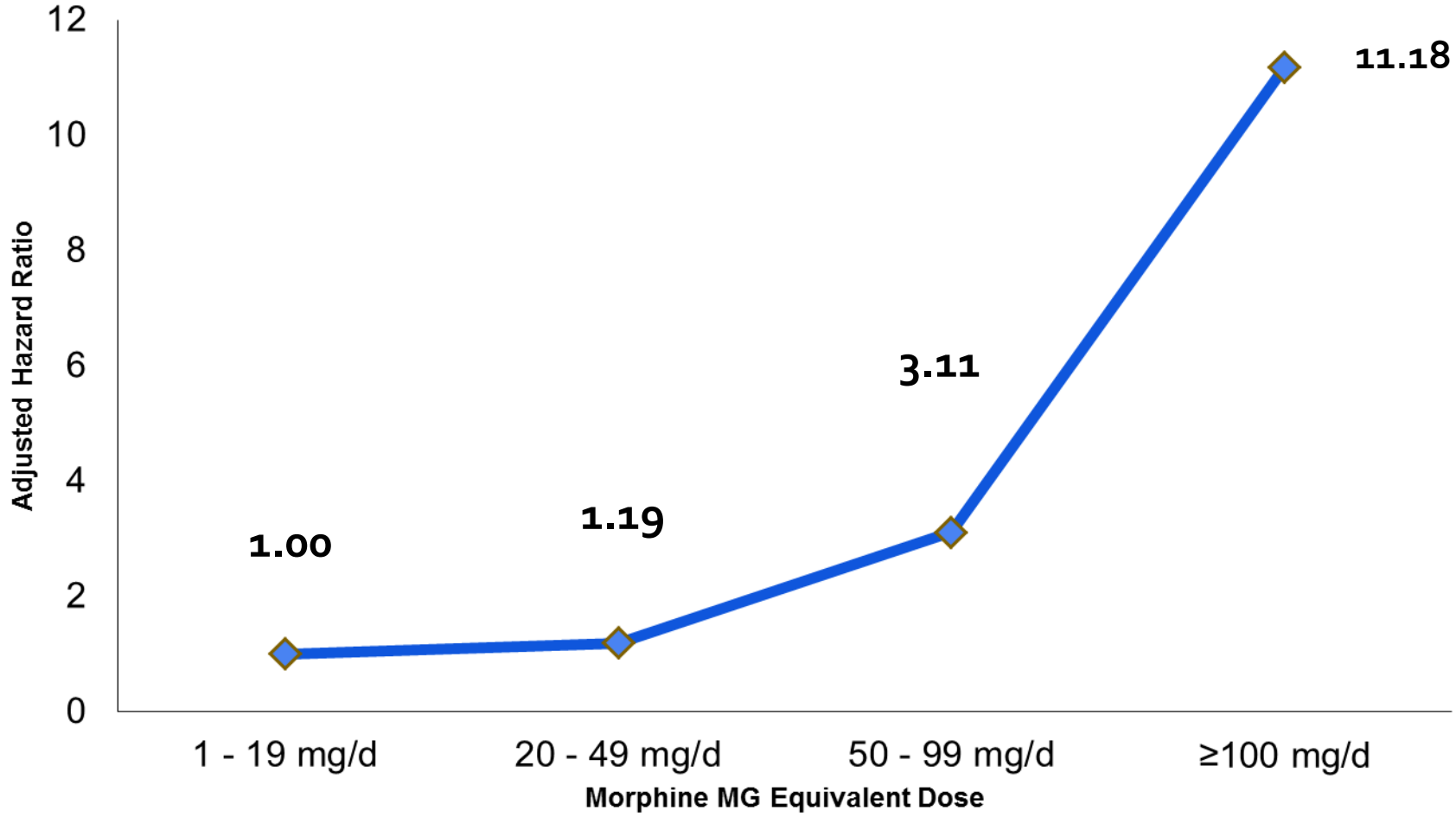
Methods: We conducted a population-based nested case-control study of Ontario, Canada, residents aged 15 to 64 years who were eligible for publicly funded prescription drug coverage and had received an opioid from August 1, 1997, through December 31, 2006, for nonmalignant pain. The outcome of interest was opioid-related death, as determined by the investigating coroner. The risk of opioid-related death was compared among patients treated with various daily doses of opioids.

Results: Among 607 156 people aged 15 to 64 years prescribed an opioid over the study period, we identified 498 eligible patients whose deaths were related to opioids and 1714 matched controls. After extensive multivariable adjustment, we found that an average daily dose of 200 mg or more of morphine (or equivalent), was associated with a nearly 3-fold increase in the risk of opioid-related mortality (odds ratio [OR], 2.88; 95% confidence interval [CI], 1.79-4.63) relative to low daily doses (<20 mg of morphine, or equivalent). We found significant but attenuated increases in opioid-related mortality with intermediate doses of opioids (50-99 mg/d of morphine: OR, 1.92; 95% CI, 1.30-2.85; 100-199 mg/d of morphine: OR, 2.04; 95% CI, 1.28-3.24).

Conclusion: Among patients receiving opioids for nonmalignant pain, the daily dose is strongly associated with opioid-related mortality, particularly at doses exceeding thresholds recommended in recent clinical guidelines.

Arch Intern Med. 2011;171(7):686-691

High Opioid Dose and Overdose Risk



* Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.

Dunn et al. Opioid prescriptions for chronic pain and overdose. *Ann Int Med* 2010;152:85-92.

A Retrospective Analysis of Overdose Deaths in Allen County, 2008-2013

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Fort Wayne-Allen County Board of Health
July 2014

Methodology

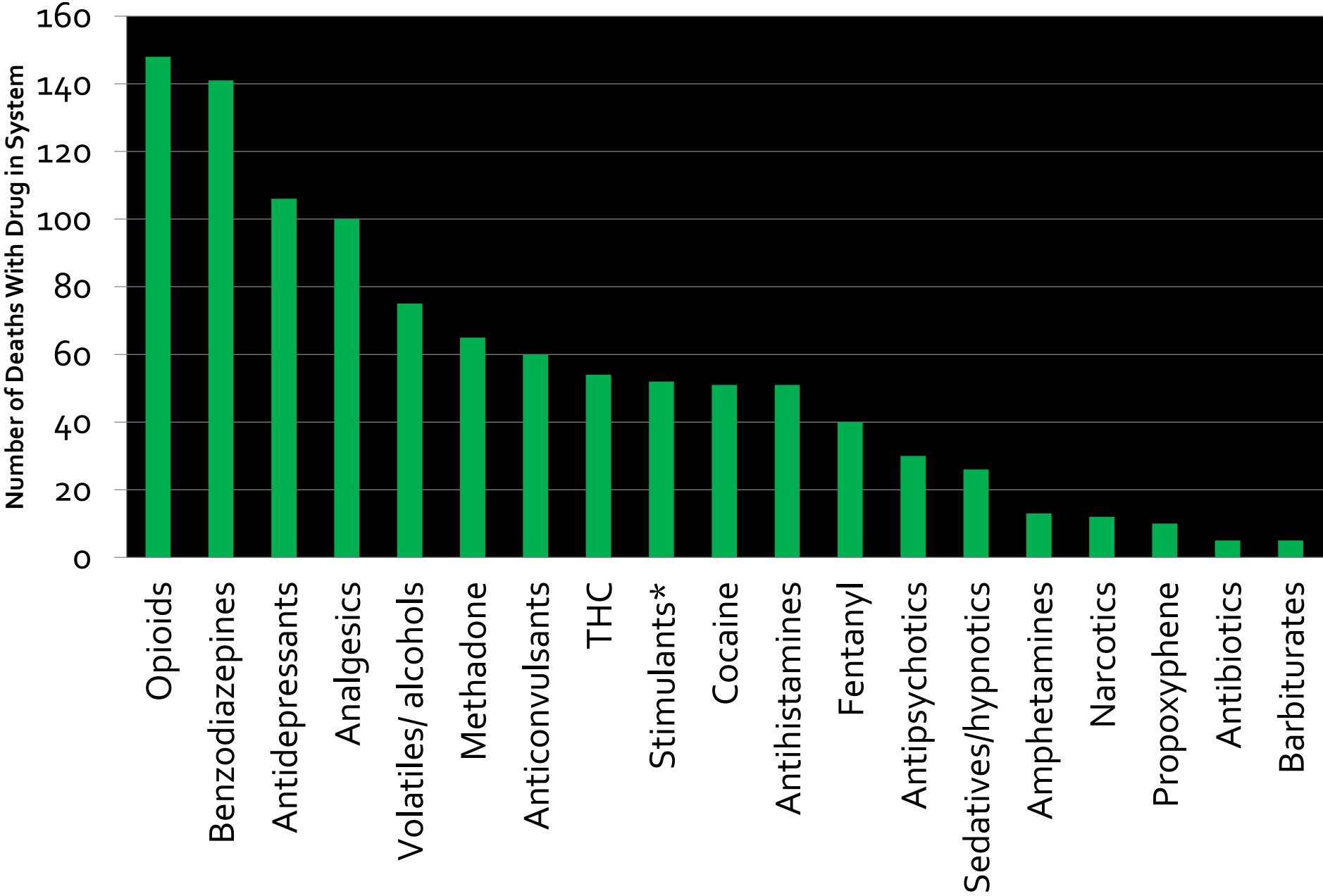
- **Collaborative Retrospective Study (2008-2013)**
  - Fort Wayne-Allen County Department of Health
  - Allen County Coroner's Office
  - Fort Wayne Medical Education Program
  - Lutheran Hospital IRB
- **Reviewed Death Certificates** – Accidental and Intentional
- **Reviewed Coroner's Files**
  - Coroner's report
  - Toxicology report
  - Police report
  - Other documents

Results

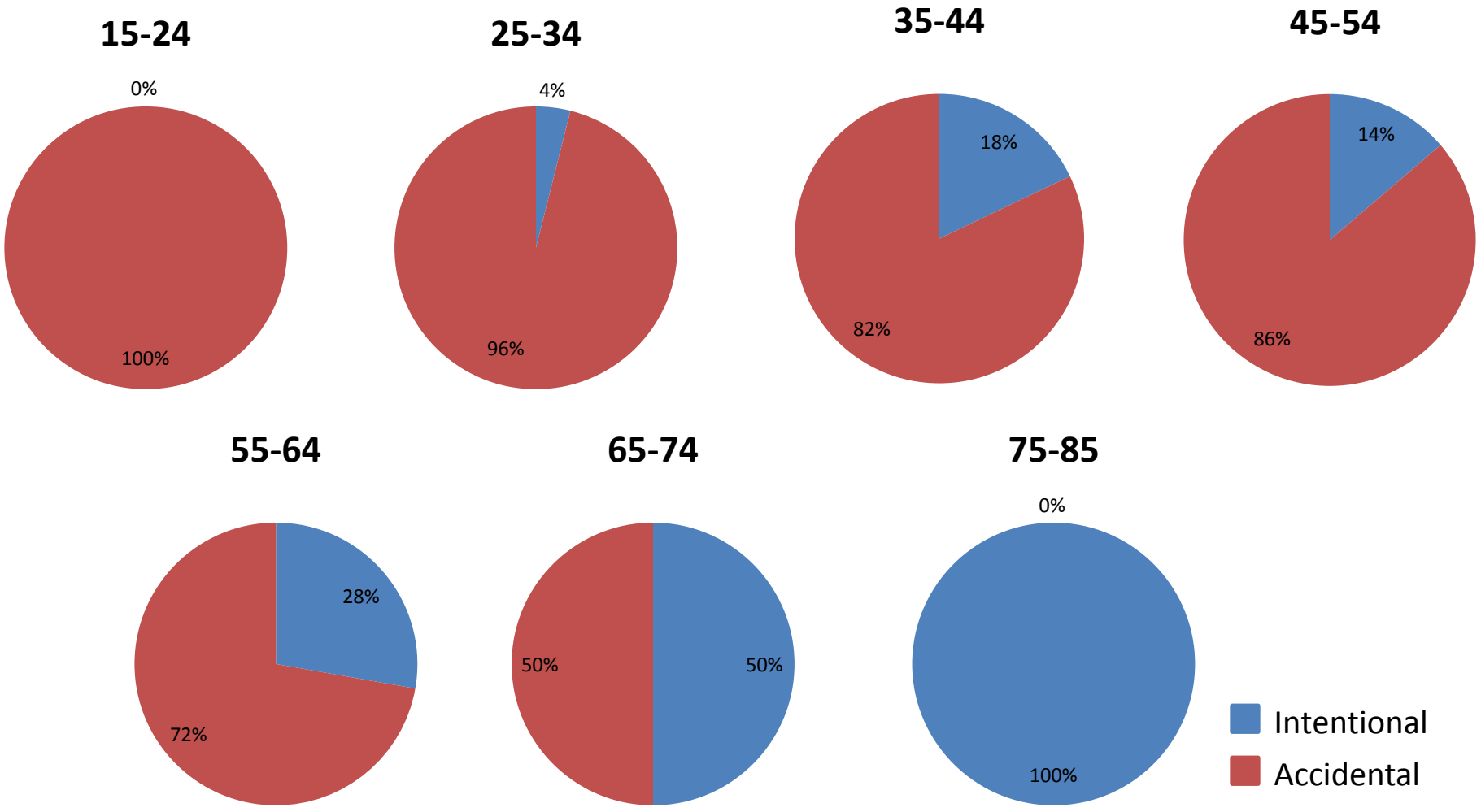
- **287 Overdose deaths**
  - 55% Increase over 6 years
  - 271 cases had confirmed manner of death
    - Accidental vs Intentional
- **2010 Allen County Rate:** 12.9 per 100,000
- **2013 Estimated Rate:** 17.1 per 100,000
- **2013 Overdose deaths = Motor vehicle deaths**

Alprazolam, Methadone, Pregabalin, Caffeine
Alprazolam, Morphine, Codeine, Hydrocodone, Ethanol, Ibuprofen, Caffeine
Morphine, Codeine, Trazodone, Amlodipine, Caffeine
Morphine, Codeine, Naloxone, Ethanol, Caffeine
Butalbital, Hydrocodone, Hydromorphone, Acetaminophen, Amitriptyline, Noramitriptyline, Caffeine
Alprazolam, Methadone, Morphine, Hydrocodone, Hydromorphone, Naloxone, Caffeine
Alprazolam, Morphine, Hydromorphone, Oxycodone, Oxymorphone, Citalopram, Nortriptyline, Caffeine
Oxymorphone, Caffeine
Cannabinoids, Cocaine, Cyclobenzaprine
Ethanol
Morphine, Codeine, Ethanol, Naloxone, Nicotine, Caffeine
Alprazolam, THC, Morphine
Ethanol, Opiates, Acetaminophen
Acetaminophen, Norfluoxetine, Diphenhydramine, Caffeine
Alprazolam, Benzoylecgonine, Fentanyl, Amitriptyline, Nortriptyline
THC, Cocaine, Benzoylecgonine, Hydrocodone, Norsertraline, Trazodone, Amlodipine
7-Aminoclonazepam, Nortramadol, Gabapentin, Dextromethorphan, Caffeine
Methamphetamines, Morphine, Duloxetine
THC, Benzoylecgonine, Methadone, Norvenlafaxine, Caffeine
Methadone, EDDP, Caffeine
7-Aminoclonazepam, THC, Methadone, EDDP, Ethanol, Caffeine, Tramadol, Nortramadol, Cyclobenzaprine
Amphetamine, THC, Cocaine, Benzoylecgonine, Naloxone, Caffeine
Morphine, Codeine
Alprazolam, THC, Morphine, Oxycodone, Gabapentin, Caffeine
Benzoylecgonine, Morphine, Ethanol
Clonazepam, 7-Aminoclonazepam, Bupropion, Caffeine
Nordiazepam, Caffeine
Methadone, EDDP, Caffeine
THC, Morphine, Ethanol, Caffeine
Oxycodone, Gabapentin, Caffeine
Fentanyl, Hydrochlorothiazide, Zolpidem, Caffeine
Salicylates, Propranolol
Ethanol, Pregabalin
Fentanyl, Hydrocodone, Hydromorphone, Gabapentin, Citalopram, Amitriptyline, Nortriptyline, Dihydrocodeine
THC, Morphine, Codeine, 6-Monoacetylmorphine, Ethanol, Caffeine
Acetaminophen, Cyclobenzaprine, Tramadol, Nortramadol, Gabapentin, Fluoxetine, Norfluoxetine, Caffeine, Diphenhydramine
Alprazolam, a-OH-Alprazolam, Buprenorphine, Narbupremorphine, Methadone, Morphine, Oxycodone, Oxymorphone
Morphine, Hydrocodone, Hydromorphone, Acetaminophen, Gabapentin
Alprazolam, Morphine, Hydrocodone, Hydromorphone, Diphenhydramine
THC, Morphine, 6-Monoacetylmorphine,Codeine, Naloxone, Caffeine
Methadone, EDDP, Caffeine, 7-Aminoclonazepam, Carisoprodol, Meprobamate, Tramadol, Nortramadol (1)

Drug Class Totals



Manner of Death by Age



Non-Terminal Pain Management - Recommendations

1. Do your own evaluation
2. Risk stratification – assess mental health and substance abuse
3. Set functional goals
4. Utilize evidence based treatments
5. Obtain informed consent + sign a treatment agreement
6. Periodic visits are required
7. Remember the 5 A's
8. INSPECT – Indiana's prescription monitoring program
9. Urine drug monitoring (UDM)
10. Re-evaluate your patient and their treatment plan when the MED enters the 30-60 mg/day range; consider consultation

“That is very nice Doctor …. but I just need my pills”

Perform your own evaluation

- Take a thorough history
- Perform a targeted physical exam
- Do appropriate tests
- Obtain and review records of past care

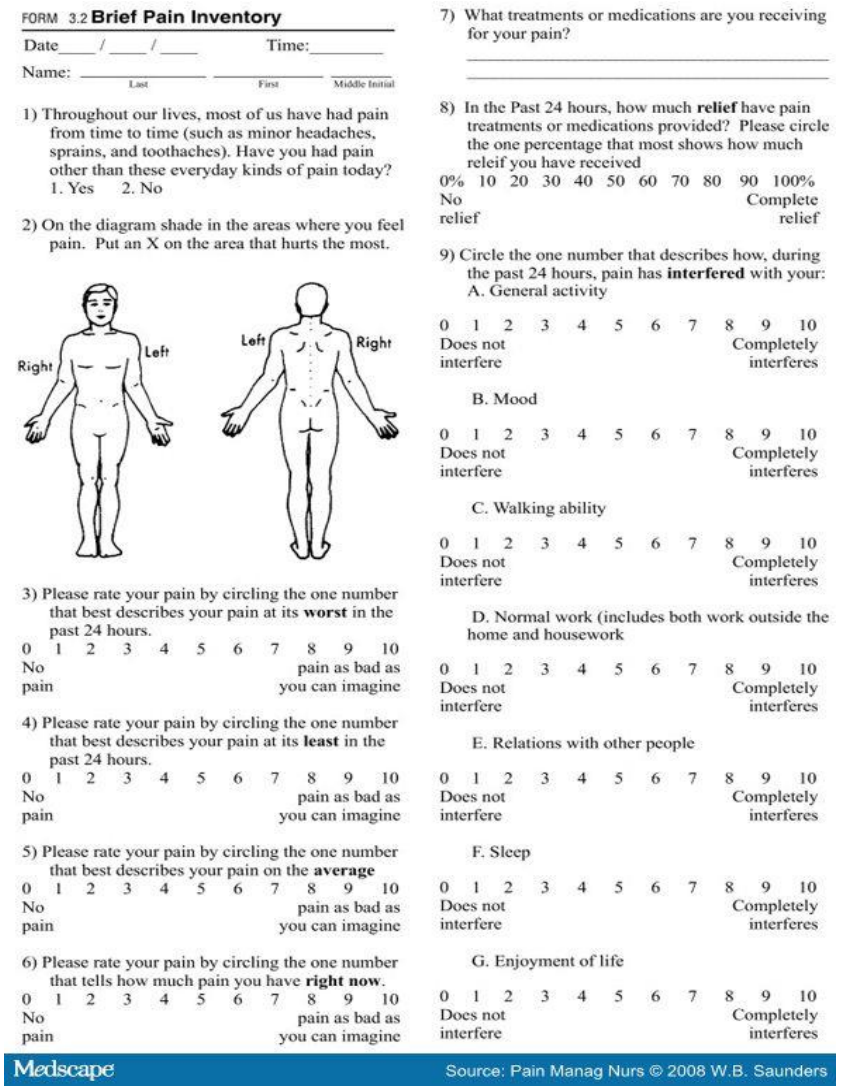
Evaluation

Ask your patient to complete a pain assessment survey like the:

Brief Pain Inventory

Then, work together to set

Functional Goals



FORM 3.2 **Brief Pain Inventory**

Date____/____/____ Time:_____

Name: _____ (Last) _____ (First) _____ (Middle Initial)

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.

Right Left Left Right

3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the **average**
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.
0 1 2 3 4 5 6 7 8 9 10
No pain — pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?
_____
_____

8) In the Past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much releif you have received
0% 10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:
A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

C. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Medscape

Risk Stratification – 2 main areas to address

MENTAL HEALTH ASSESSMENT

RISK FOR SUBSTANCE ABUSE

Mental Health Assessment – Survey Tools

Treat patients that you identify with:

- Depression (PHQ-2, PHQ-9)
- Post Traumatic Stress Disorder
- Anxiety/Panic Disorder (GAD-7)
- Alcohol/Substance Use Disorder (AUDIT, DAST)

Substance Abuse Assessment - Survey Tools

Ask patients about any past or current history of **substance abuse** (alcohol, Rx meds, or illicits) prior to initiating treatment for chronic pain with opioids

- **ORT** – Opioid Risk Tool
- **Others** (SOAPP, COMM)

These survey tools are available at:
www.bitterpill.in.gov

An Approach to Managing Chronic Non-Terminal Pain

Pt. with chronic pain affecting function, and inadequate response to current therapies.

→ Has a cause of pain been firmly established? If so, document. If not, determine plan for workup and set functional goals.

→ Have appropriate non-pharmacologic interventions been tried? (Box 1)

No → - Trial of appropriate non-pharmacologic interventions.

Yes → Have appropriate non-opioid medications been tried? (Box 2)

No → - Trial of 2nd line agents
- Consider referral to orthopedics/neurosurgery, rheumatology, psychiatry, or a pain specialist for evaluation/management of treatable conditions.

Yes → Are opioids a reasonable choice based on pt's other meds, allergies, mental status, and type of pain?

No → - Referral to a pain management specialist for evaluation/treatment.
- Document in the referral if you feel opioids are not indicated.

Yes → Assess mental health and substance abuse risk (e.g. ORT, PHQ-9 surveys).

ORT ←

High or moderate risk → Consult a Mental Health Professional or Addiction Specialist re: appropriateness of opioids (and for treatment, as appropriate).

Also ←

Low Risk →

→ Obtain an INSPECT report & perform UDM (Box 3).

Abnormal → - Avoid opioids if risk > benefit or if "red flags" are present
- Explain decision to patient and assure them you will work to find other ways to manage their pain (reconsider options as outlined in Boxes 1 & 2).

Normal →

Consider trial of opioids following these steps:
1) If appropriate, select opioid (Box 4)
2) Establish purpose & endpoint to Rx
3) Educate patient re: safe use/storage & risks
4) Establish & adhere to an opioid agreement
5) Follow-up in 1 month re: functional status and pain control.

Opioids not helping achieve functional goals, violation of tx agreement or other Rx misuse → - Discontinue opioids (protocol on page 2)
- Consider referral to a pain management specialist for evaluation and treatment (using non-opioid options).

Improved fxn, pt. adheres to tx agreement, and expect longterm Rx. → Patient should return at regular intervals for f/u evaluation, incl. periodic monitoring of endocrine fxn (e.g. testosterone).

Reassess patient at regular intervals (at least once every 3-4 months), more frequently if patient is not at goal or if risk factors are present. Attempt an opioid taper when appropriate.

Table 1. Opioid risk assessment tool[1]

	Female	Male
FHx substance abuse		
Alcohol	1	3
Illicit drugs	2	3
Prescription drugs	4	4
Personal hx substance abuse		
Alcohol	3	3
Illicit drugs	4	4
Prescription drugs	5	5
Age between 16 – 45	1	1
Hx preadolescent sexual abuse	3	0
Psychiatric disease		
OCD, bipolar, schizophrenia	2	2
Depression	1	1

Scores: 0 – 3 Low Risk
4 – 8 Moderate risk
≥8 High risk

Red flags that may ↑ risk: Asking for specific brand name opioids: frequent changing of PCPs or hospitals; coming from out of state; history of being taken off opioids by former provider.

Box 1. Non-pharmacologic interventions[3]

MSK/inflammatory pain:
- Ice or heat packs
- Progressive exercise, stretching, yoga, relaxation, meditation
- Physical therapy, TENS therapy, hypnosis
- Manipulation (D.O., chiropractor)
- Occupational therapy, work conditioning
- Massage, acupuncture, biofeedback, Cognitive Behavior Therapy
- Surgical evaluation (e.g. joint replacement for OA)
- Interventional pain modalities
- Self-care; new mattress, new shoes
- Counseling (tobacco cessation, nutrition/weight loss)

Visceral pain:
- Dietary and other GI interventions

General:
- Review sleep hygiene

Box 2. Non-opioid medications for chronic pain[2]

MSK/inflammatory pain:
- Acetaminophen (max. 3-4 g/day)
- NSAIDs (in select nonelderly pts, monitoring GI/renal toxicity)
- Topical anesthetics (lidocaine – cream, ointment, patch)
- Anti-inflammatory creams (diclofenac cream, gel)
- Steroid injections
- Muscle relaxants (cyclobenzaprine)

Neuropathic pain:
- Tramadol (weak opioid)
- TCA's (SOR-A): nortriptyline, desipramine
- Topical anesthetics, Neuropathic creams
- SNRI's (SOR-A): duloxetine (Cymbalta®), milnacipran (Savella®)
- Anticonvulsants: gabapentin (Neurontin®), pregabalin (Lyrica®)

Visceral pain:
- NSAIDs and/or acetaminophen
- Antispasmodics (e.g. dicyclomine)

Restore sleep:
- Melatonin, TCA's, trazadone
- Avoid BZD's due to tolerance/abuse risk

Box 3. Urine Drug Monitoring (UDM) – see Toxicology Section
- Obtain urine drug screen at start, then random testing ≥ once/yr
- List controlled substances that the patient is prescribed on lab requisition, including dose/frequency & time/date of last dose.
- "Opioids" reported on UDM are codeine and morphine only.
- Specific assay required for synthetic opioids (hydro/oxycodone).

Box 4. Opioid selection[2] (augmenting other treatments)
- Lack of evidence for long-term benefit in chronic non-cancer pain (e.g. low back pain). Avoid use in chronic H/A, fibromyalgia, IBS.
- Begin with a short-acting opioid (e.g. hydrocodone/oxycodone → morphine) while titrating up; transition to a single, long-acting form (e.g. MS Contin®) when a stable daily dose is established.
- When switching to a different opioid, calculate the Morphine Equivalent Dose (MED) and reduce by 25-50% initially for safety.
- Avoid MED > 50-100 mg/day dose to minimize overdose risk.
- Breakthrough dosing has not been shown to improve outcomes.
- Avoid concurrent use of multiple opioids or co-tx with BZD's.
- Brand name formulations (e.g. Percocet®, Oxycontin®, Opana®) have high street value and may pose increased diversion risk.
- Avoid methadone for safety (ADR's, long variable T-½, OD risk).

Gregory Eigner, MD

* See additional credits listed on page 2.

Box 1. Non-pharmacologic interventions[3]

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Visceral pain:

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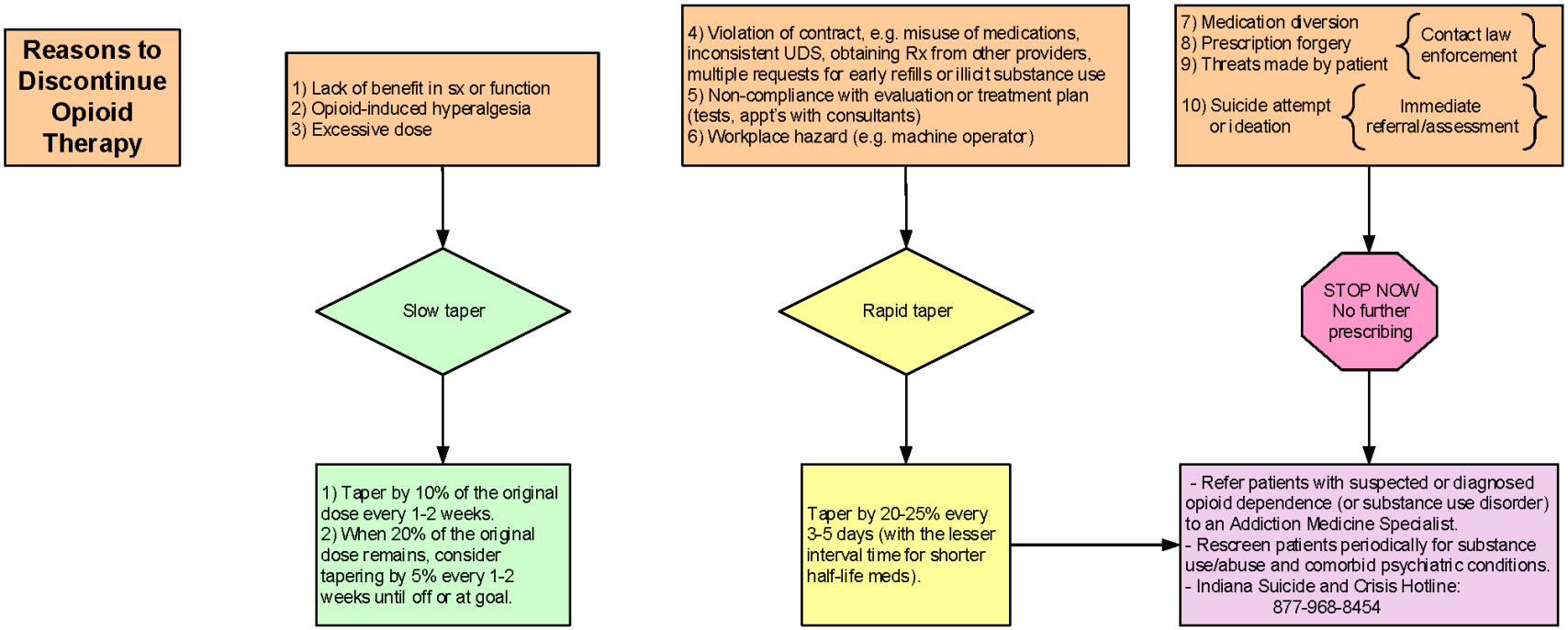
Discontinuing Opioids



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References

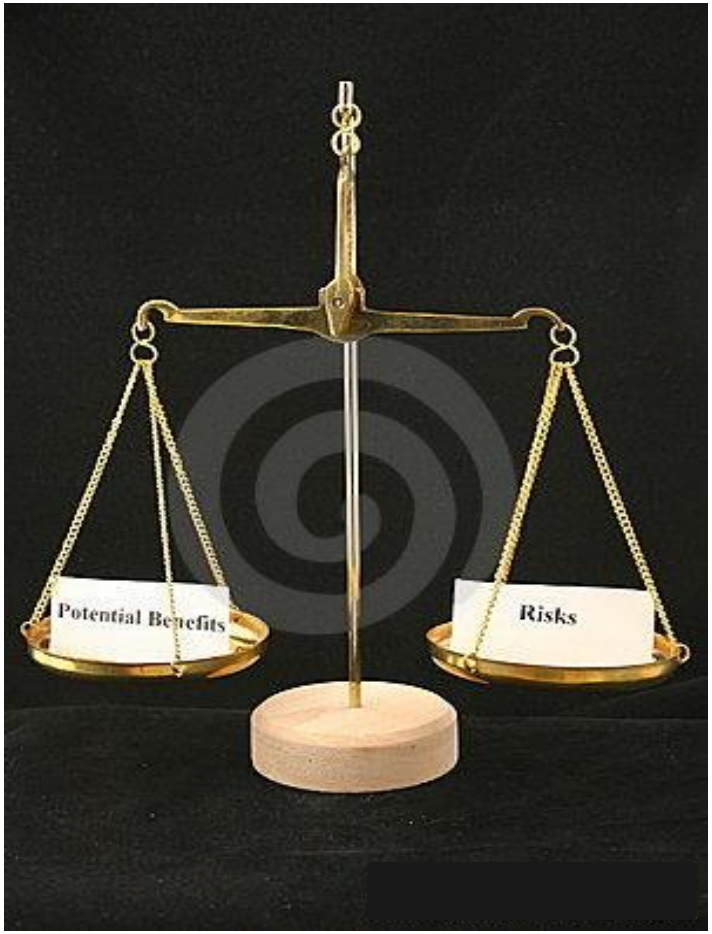
1. "**Opioid Risk Tool**" developed by Lynn Webster, MD (reprinted with permission)
2. Berland D, Rodgers P, Rational Use of Opioids for Management of Chronic Nonterminal Pain. *Am Fam Physician*. 2012 Aug 15;86(3):252-258.
3. Jackman RP, Purvis JM, Mallett ES, Chronic Nonmalignant Pain in Primary Care. *Am Fam Physician*. 2008 Nov 15;78(10):1155-1162.

June 2013

Medications that may be used to manage withdrawal symptoms (for patients that remain under your care):

1) Clonidine 0.1 – 0.2 mg q6h, or transdermal patch 0.1 mg/24h (monitor BP).
2) Promethazine 25 mg q6-8h, as needed for nausea.
3) Short term use of a non-BZD sleep aid for insomnia, if indicated.

Prescribing Opiates: Informed Consent



- Discuss the **risks and benefits** of opioid treatment with your patients, including common adverse effects.
- Provide a clear explanation to help patients understand key elements of their treatment plan.
- Counsel women of child-bearing age about the potential for fetal opioid dependence and neonatal abstinence syndrome (NAS).

Review and Sign a Treatment Agreement

- Long term benefit of treatment with opioids has not been established
- One prescriber, one pharmacy
- Medication is for patient's use only; no sharing or selling meds
- Keep medications safe; lost or stolen Rx will not be replaced
- Renewals are contingent on scheduled appointments
- No phone refills
- There is potential for addiction, and abstinence syndrome if the medication is stopped abruptly
- Prescription Drug Monitoring (INSPECT) will be reviewed regularly
- Participation in Urine Drug Monitoring, as directed
- Failure to follow policies or lack of functional benefit with the treatment will result in discontinuation of the opioid trial (taper)

INSPECT
Indiana's Prescription Drug Monitoring Program

- Use INSPECT regularly for new and established patients to detect unsafe patterns of medication use.
- Tracks all controlled substance prescriptions filled state-wide.
- INSPECT is free and easy to use; www.in.gov/inspect
- INSPECT reports are required initially and annually as the minimum. Consider more regular use!

* Inspect Rx data is 99% accurate
* 3-7 day lag time for data entry

» View Request
» New Request
» Unsolicited - Received
» Unsolicited - Send
» Practitioner Self-Lookup

Other Links

» Alerts (344)
» Info Center
» FAQ
» Related Links

Latest News

Request

Patient

Patient Details

Last Name: *

First Name: *

Middle Name:

Birth Date: *

Gender:

Contact Details

Street:

City:

State: IN

Zip:

Aliases

Add

Prescription Range

Set default to last 12 months date range

Date Filled From: 03/12/2012 *

Date Filled To: 03/12/2013 *

Request To State(s)

Arizona Connecticut Illinois Kansas Michigan North Dakota OHIO VIRGINIA

The interstate request may take longer for response

I certify that the information I have entered above is accurate. *

Create

INSPECT
WWW.IN.GOV/INSPECT

Indiana Prescription Monitoring System
402 W Washington St, Room W072; Indianapolis, IN 46204
Phone: (317) 234-4458 Email:inspect@pla.in.gov Fax:(317) 233-4236

Inspect RX Report

T1MOTHY AL3XANDER

Date: 03-04-2013

Search Criteria: ((Last Name Begins 'Al3xander' AND First Name Contains 'T1mothy') AND (D.O.B = '11/20/1958' AND Gender = 'M' AND State = 'IN')) AND Request Period = '03/04/2012' To '03/04/2013'

Demo patient

Patients that match search criteria

Pt ID	Name	DOB	Address
5641	Al3xander, T1mothy	11/20/1958	123 Grand Circle Drive Indianapolis IN 46237
7862	Al3xander, T1mothy	11/20/1958	123 Grand Circle Dr Indianapolis IN 46237
7863	Al3xander, T1mothy	11/20/1958	123 Grand Circle Indianapolis IN 46237

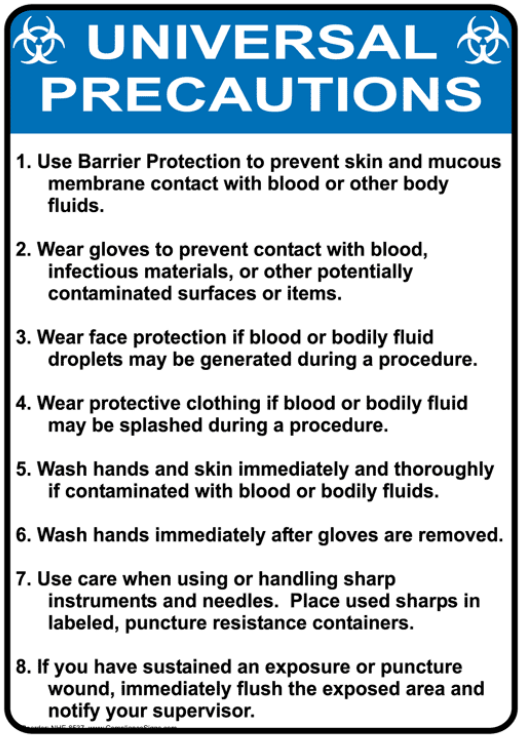
Prescriptions

Fill Date	Product, Str, Form	Quantity	Days	Pt ID	Prescriber	Written	Rx #	N/R	Pharm	Pay
02/01/2013	CARISOPRODOL, 350 MG, TABLET	60.00	30	5641	How Wi63	01/15/2013	00551	N	201312	01
01/15/2013	CARISOPRODOL, 350 MG, TABLET	60.00	30	5641	How Wi63	01/15/2013	00679	N	201313	01
01/14/2013	OXYCODONE AND ACETAMINOPHEN, 10 MG;325 MG, TABLET	120.00	30	5641	How Wi63	01/14/2013	00547	N	201312	01
01/01/2013	CARISOPRODOL, 350 MG, TABLET	60.00	30	5641	Mey Ka63	11/26/2012	11685	N	20137	04
12/20/2012	OXYCODONE AND ACETAMINOPHEN, 10 MG;325 MG, TABLET	120.00	30	5641	How Wi63	12/20/2012	19503	N	201315	04
12/19/2012	OXYCODONE AND ACETAMINOPHEN, 325 MG;5 MG, TABLET	20.00	3	5641	Lan Ar63	12/19/2012	21054	N	201316	04
12/17/2012	HYDROCODONE BITARTRATE AND ACETAMINOPHEN, 325 MG;5 MG, TABLET	10.00	2	5641	Hos L363	12/17/2012	41180	N	201316	04
12/01/2012	CARISOPRODOL, 350 MG, TABLET	60.00	30	5641	Mey Ka63	11/26/2012	11655	N	20137	04

Universal Precautions

Chronic Pain Guidelines function most effectively when the process you implement applies to all chronic pain patients …

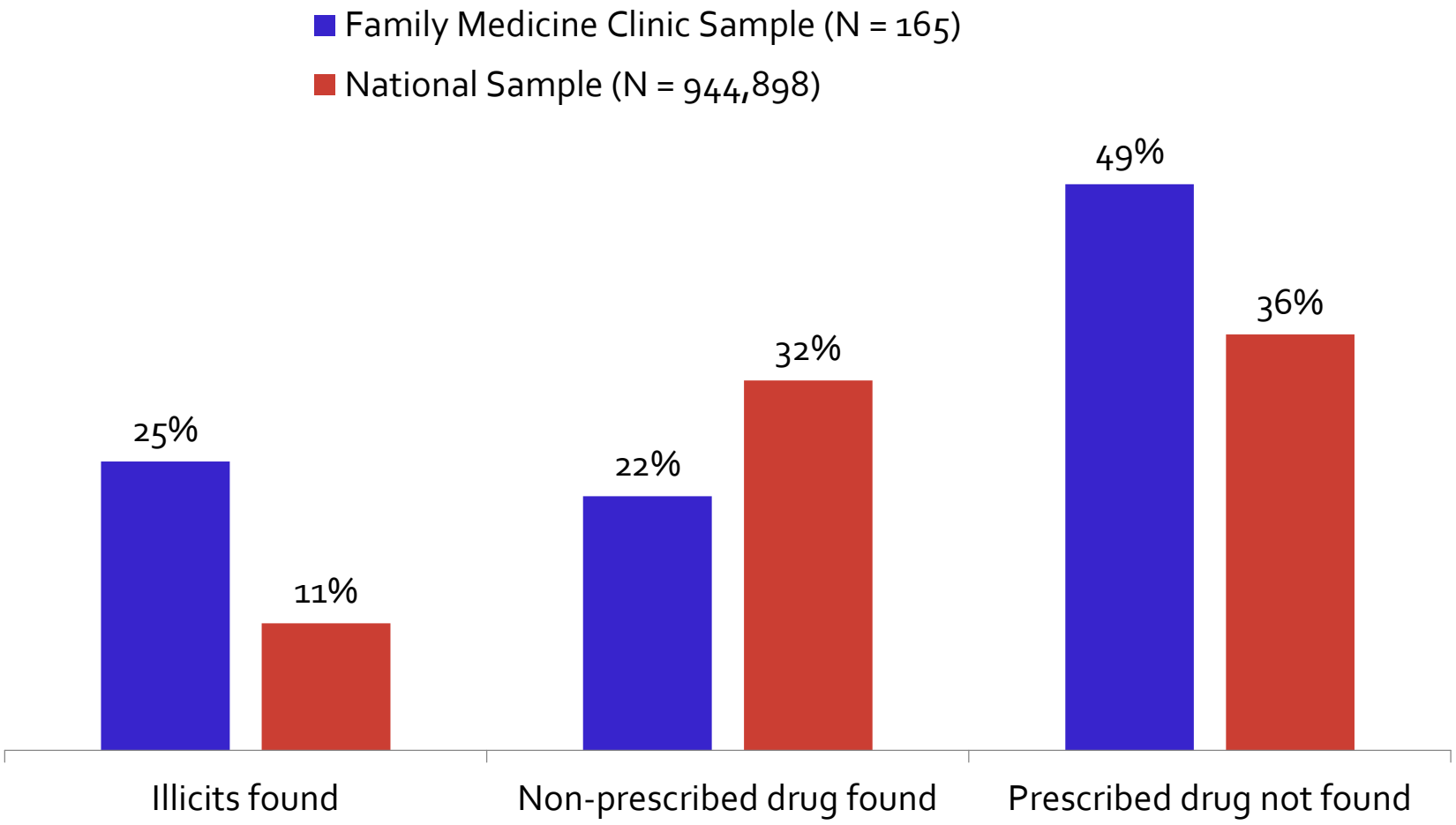
Universal Precautions



Urine Drug Monitoring

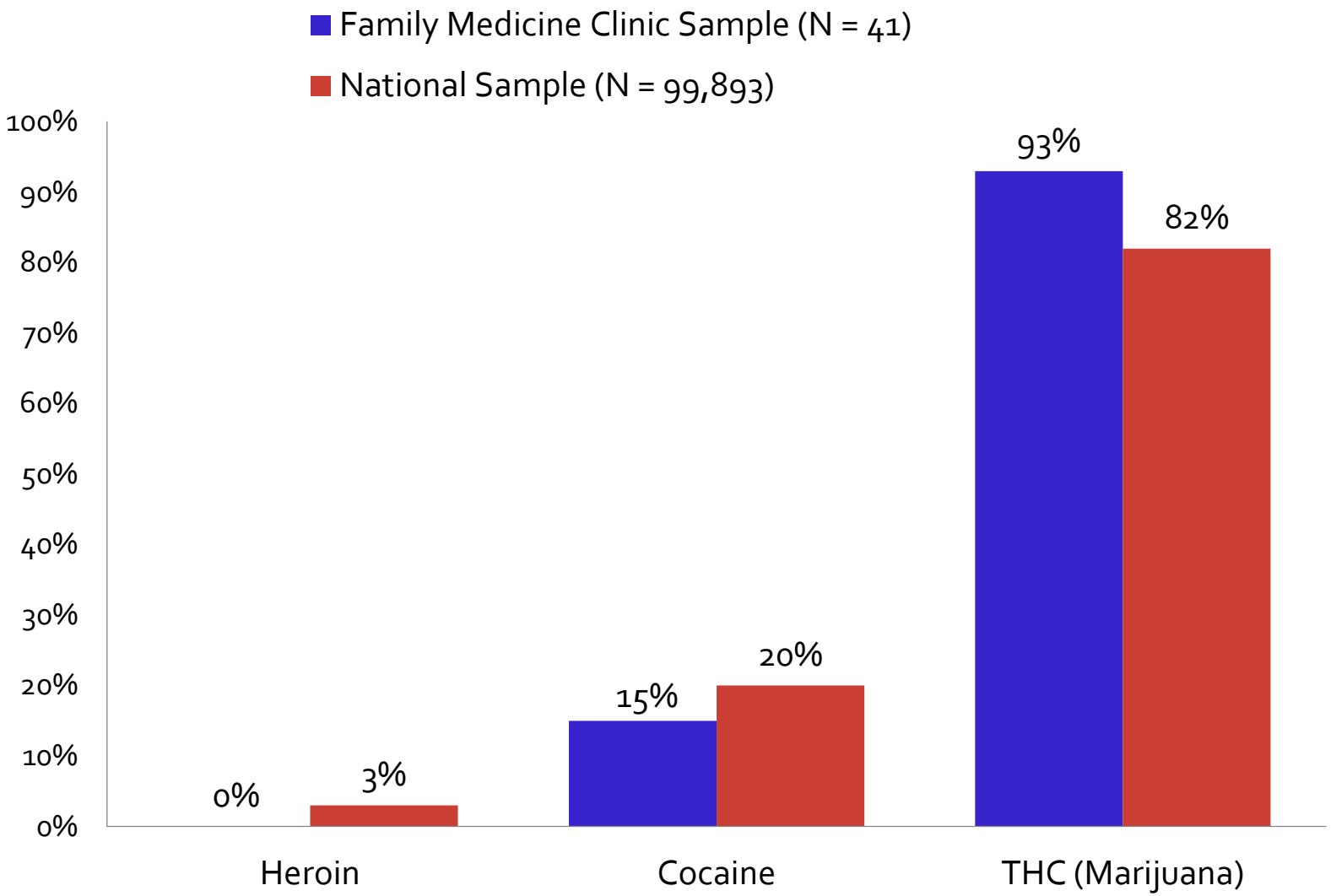
- UDM is a useful objective tool that complements your other risk assessments.
- Discussion with patients regarding the need for UDM should legitimately be based on their **SAFETY**

Urine Drug Monitoring Data in a Practice Setting



Reporting Period: January – December 2012

UDM – Illicit Drug Use in an Urban Practice Setting



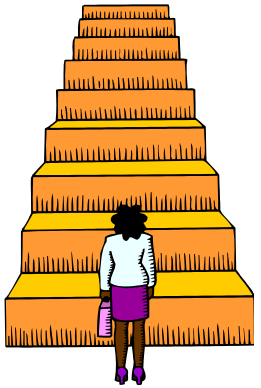
Reporting Period: January – December 2012

Urine Drug Monitoring Costs

- Available to all physicians in Indiana
- Cost for a screening immunoassay (IA) is $100, plus $35 per confirmatory test, as needed. Usual average is 2.5 confirmations per specimen = about **$200** total
- Max. total cost for **self pay patients** is **$60-100**, including confirmation testing

Challenges to Caregivers' Adoption of Opioid Guidelines for Chronic Pain

- Lack of Time, EMR's/poor templates
- Lack of specific knowledge (e.g. UDM)
- Patient expectations
- Decreased patient satisfaction
- Strained physician-patient relationship
- Belief that high-dose opiates are safe
- Belief that this change is not necessary



The Power of "Teamwork"

Physician, NP, PA:

- Evaluation
- Diagnosis
- **Problem-solving**

Functional assessment and evidence-based treatment

Nurses, staff:

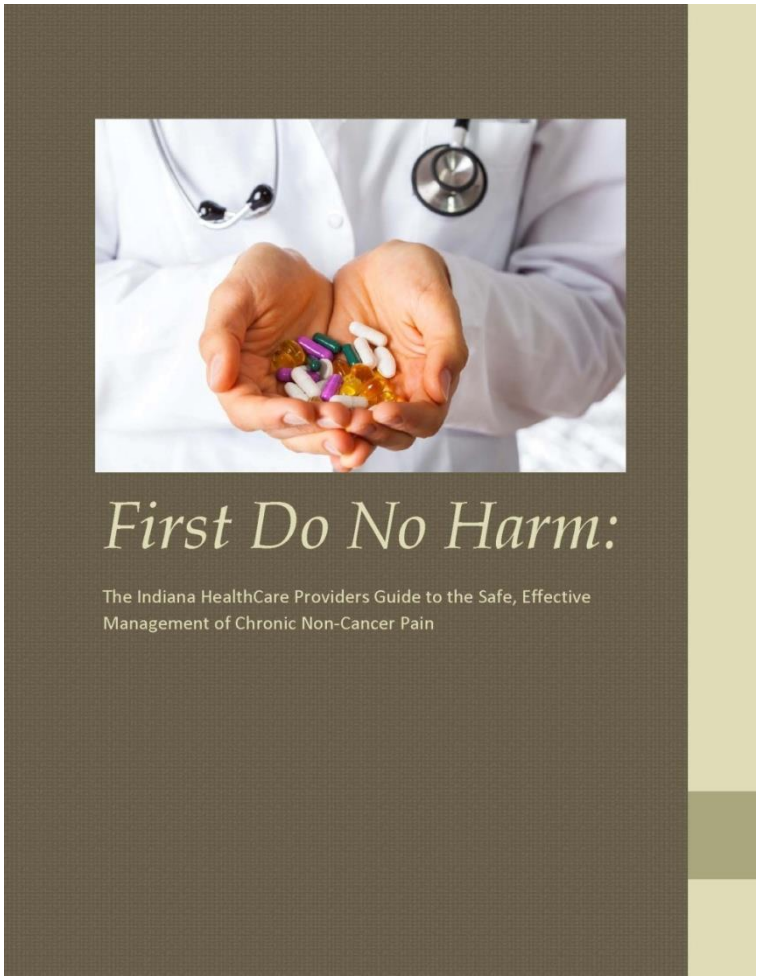
- Organization
- Part of routine
- **Deliver Consistency**

Ensure MH surveys are completed and INPSECT + UDM get done

Develop Policies & Optimize Workflow

- Educate office staff
- Protocol for patients
- Obtain records of past care
- ?Prescribing on 1st visit
- Refill policy
- Lost scripts, safekeeping
- Missed visits
- Urine Drug Monitoring
- Ceiling for opioids?
- Benzo policy (e.g. opioids or BZD's … not both)

Healthcare Provider Toolbox: www.bitterpill.in.gov



A comprehensive "Clinical Resource" to assist you in managing your patients with chronic pain

Bitterpill.in.gov

- Provides links to clinical resources/toolbox
- Provides templates for various surveys & forms
- Links to websites with more in-depth information for you and your patients
- Talking points for difficult conversations

Tips for Implementing in Your Practice

The prevalence of lifetime substance use disorders ranges from 36% to 56% in patients treated with opioids for chronic back pain; forty-three percent of this population has current substance use disorder (SUD) and 5% to 24% have aberrant medication-taking behaviors.[1]

Overview

Physicians must be able to safely and effectively prescribe scheduled drugs and, at the same time, must identify and manage misuse and abuse in their practices – all in a relatively short office visit. You will likely find a team approach the most cost-effective strategy for screening, assessing, educating and monitoring your chronic pain patients receiving opioid therapy. Many of the screening tools can be self-administered while in the waiting room or exam room, scored by your nursing staff and ready for your review prior to seeing the patient.

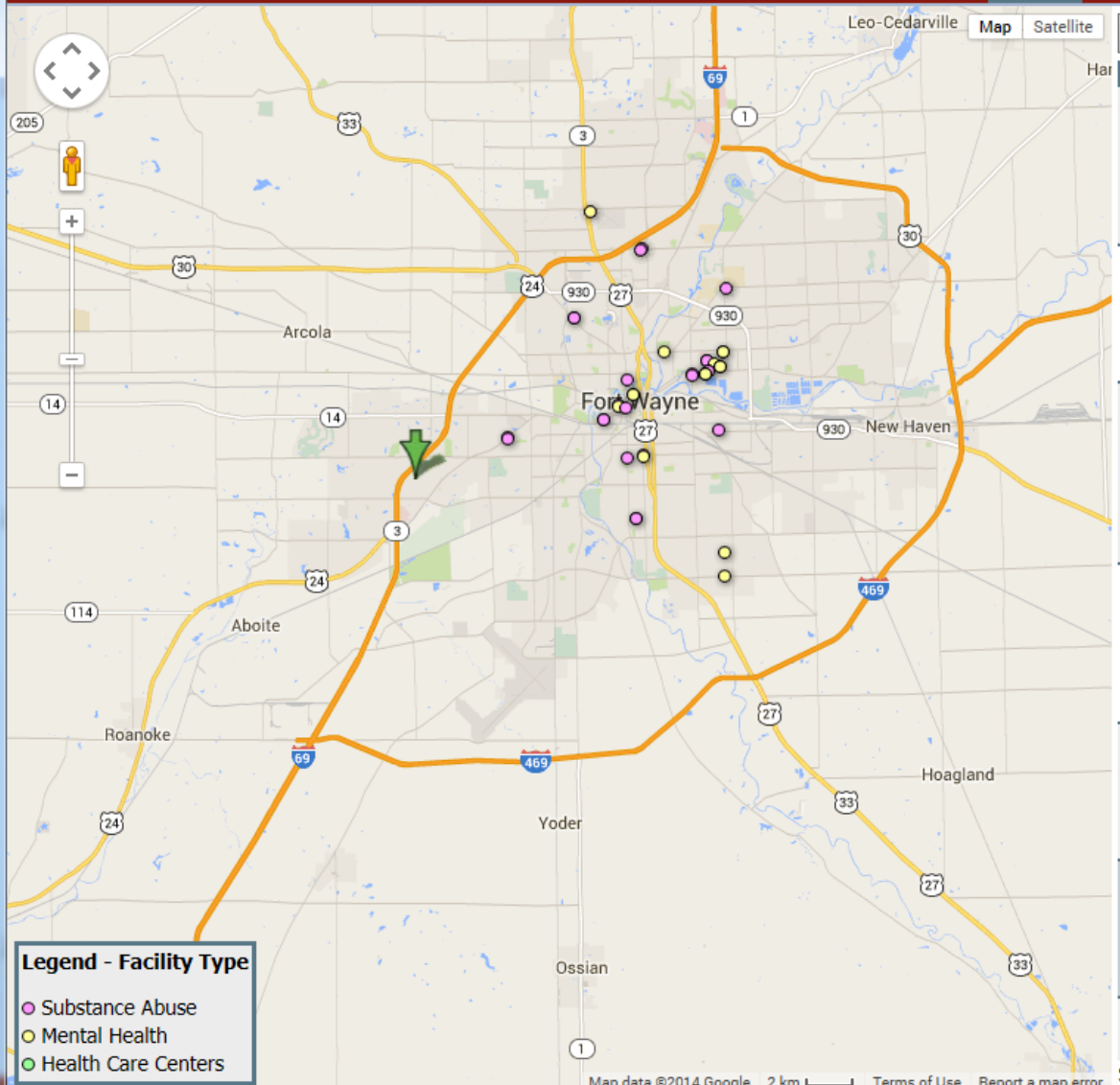
Recommendations

1. Review the Medical Licensing Board Prescribing Rules with your office staff.
2. Review and determine which of the available mental health and addiction screening tools and pain assessment tools you will be using in your practice.
3. Have your office/nursing staff become familiar with the instruments and how to score.
4. Obtain an INSPECT provider number at the INSPECT Prescription Monitoring Program and train your office staff on how to download a report as part of the patient's chart preparation.
5. Determine which drug testing laboratory you would like to use and obtain protocol for specimen collection and submission.
6. Select and modify, if needed, a Treatment Agreement that is most compatible with your practice and ensure that nursing staff is comfortable discussing in more detail after you leave the room.

Skip Navigation

Substance Abuse and Mental Health Services Administration
SAMHSA
Behavioral Health Treatment Services Locator

Find Facility
Fort Wayne, IN 46804, USA
State | County | Distance 5 miles | Options
Service: Substance Abuse (SA) | Mental Health (MH) | SA & MH | Health Care Centers | Veterans Affairs



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Facility Listing Information

1 **Counseling Services and Consulting LLC** — 2.30 miles
4660 West Jefferson Boulevard
Fort Wayne, IN 46804
260-432-9916
www.counselingservicesandconsulting.com
Directions | More Information

2 **Counseling Servs and Consulting LLC** — 2.34 miles
4660 West Jefferson Boulevard
Fort Wayne, IN 46804
260-432-9916
Directions | More Information

3 **Hope House II**
Marthas Place — 4.66 miles
1129 Garden Street
Fort Wayne, IN 46802
260-424-3711
www.hopehouseinc.us
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4 **Hope House I** — 4.67 miles
1115 Garden Street
Fort Wayne, IN 46802
260-424-2471
www.hopehouseinc.us
Directions | More Information

5 **Center for Solutions** — 5.03 miles
2722 Fairfield Avenue
Fort Wayne, IN 46807
(260) 456-8616
Directions | More Information

6 **Saint Joseph Hospital** — 5.10 miles
700 Broadway
Fort Wayne, IN 46802
260-425-3606
Directions | More Information

7 **Saint Joseph Health System**
Saint Joseph Hospital — 5.12 miles

Show 100 per page
<< < 1 2 3 4 5 6 7 > >>

Guideline Summary …

- Preserve **patient safety** first and foremost.
- **Perform your own evaluation**, including review of records and ordering appropriate lab and imaging studies as needed
- Screen for **mental health** problems and **substance abuse**, using available survey tools to supplement your history.
- Set **Functional Goals** and expect your patient to play an active role in their treatment plan. Not just pills!

Guideline Summary …

- **Monitor compliance** using objective tools; **INSPECT** and **UDM** are valuable resources. They are reliable and effective!
- **Delegate tasks** (e.g. initiating mental health surveys, pulling INSPECT reports) to support staff for efficiency.
- **Obtain patient consent** for treatment with opioid medication, including a discussion of pertinent risks and adverse effects.
- A reasonable therapeutic window for treatment of most legitimate medical diagnoses is 15-30 mg MED per day … **"LESS is MORE"**

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